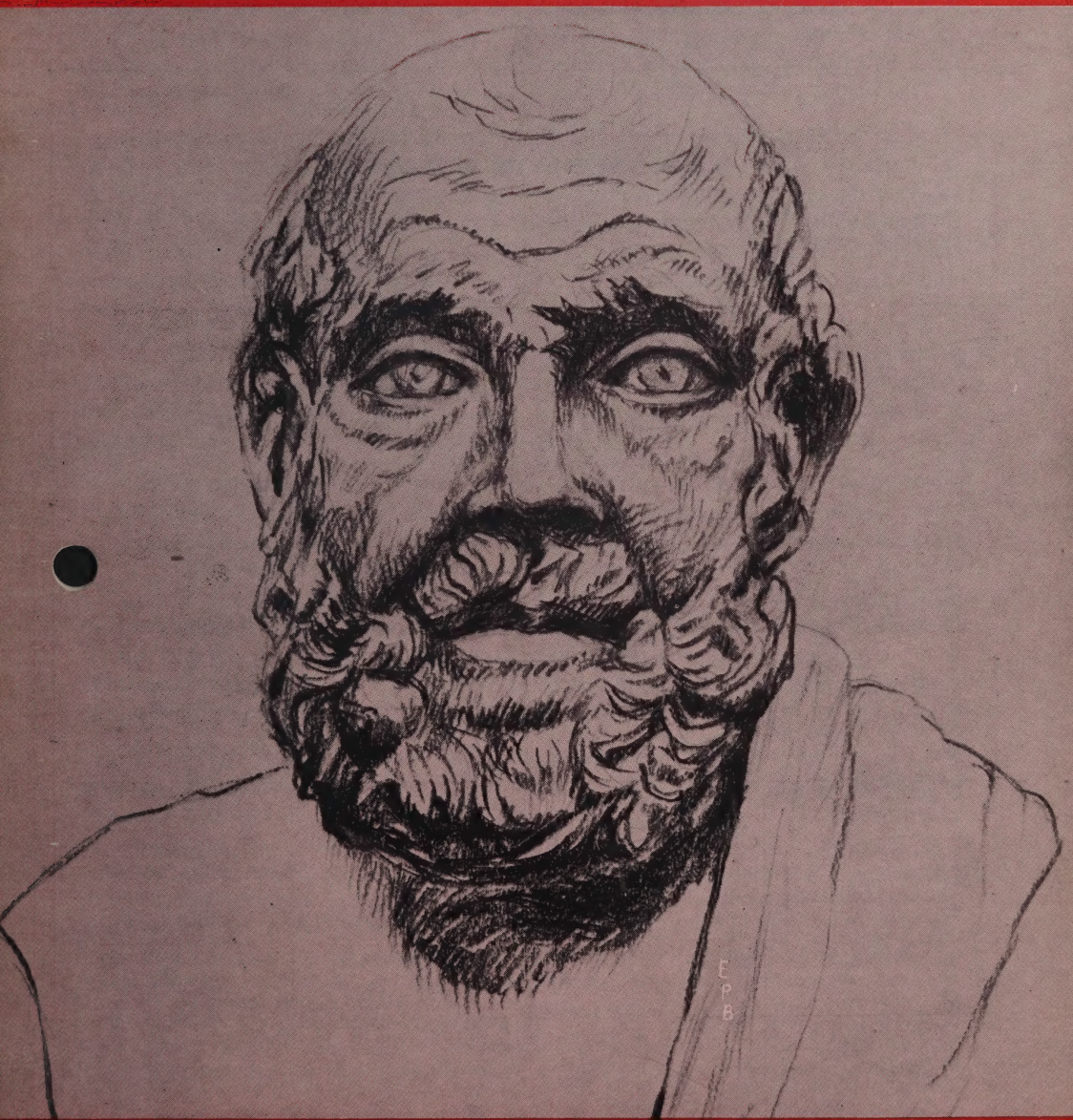
The Hampden Hippocrat

DECEMBER, 1967



Season's Greetings

The Hampden Hippocrat

Volume XXIII No. 10

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EDITORIAL

Ethics and Philosophy

At one time or another practically every philosopher of note has concerned himself with the problem of ethics by invariably asking: "How do we know what is good or evil, right or wrong?" He would then proceed to probe, to contemplate, to discourse and finally to formulate a philosophic concept of what he considered good or bad, ethical or unethical, in this world.

Between the early Greek philosophers and the modern exponents of pragmatism and existentialism, dozens of thinkers have expressed a variety of ethical concepts and opinions. These, to be sure, were not always new or original. On the contrary, many of them were admittedly modifications or combinations of other epistemological points of view. Nevertheless, if we consider their fundamental or predominant elements, we find that they lend themselves to a classification into the following two categories:

1. The ethical concepts of the earlier philosophers, according to which all good and evil are *absolute*; they are inherent in the nature of the universe; they were established at the beginning of time; they apply to all situations at all times; they are forever true, never changing.

2. In contrast to the absolutism of the earlier thinkers, the philosophers that followed, beginning perhaps with Hobbes, Spinoza and Locks, believed that good and evil are *relative* terms. Their criteria are to be determined by a study of the particular conditions at hand. This concept considers the consequences of a particular act and determines the ethical quality of the act in terms of the ultimate good. Shall we always apprise the distraught patient of the hopelessness of his condition? The *absolutist* would say "yes, always tell the truth." The *relativist*, on the other hand, would want to weigh his decision against the tragic emotional consequences that may possibly ensue.

As divergent as these two approaches may seem they more or less say one and the same thing, at least as far as modern medical ethics are concerned. In the final analysis, according to Dr. Richard T. Barton* ". . . the present-day philosophers, religionists, and scientists are talking about three broad concepts: *freedom, truth, and love*; and it is on the basis of these three ideals that we should judge medical-moral questions. In making an ethical judgment (whether regarding capital punishment, abortion, sterilization, transplantation, etc.), the legislator, the physician, and the citizen should ask of themselves the following three questions: (1) Does my position permit the individual his personal freedom and his freedom to choose? (2) Is my position based on scientific probabilities, rather than on mere tradition or intuition? (3) Is my position consistent with an empathy and charity that I would expect from someone who truly loves me?"

"These three questions," in the opinion of Dr. Barton, "are the 'Koch's postulates' of modern medical ethics."

Max Millman

* Barton, R. T.: Sources of Medical Morals, JAMA 193:133-138 (July 12) 1965.

Christmas

REVEREND MR. FREDERICK DRIFTMIER
South Congregational Church, Springfield

What can I say to you about Christmas that you do not already know? Probably nothing! All I can do is to remind you that Christmas is *the great reminder.* We all need to be reminded that love is God's gift to the world — reminded not by music and scripture alone, but reminded with gifts and feasting and dancing. Indeed, we need this so much that if we did not have Christmas, we would have to have something else to take its place.

If the whole idea of Christmas could be wrapped up in one tidy little package, it would be: *God is love; the world is an expression of his love, and love is incarnate in human life.* Christmas means that the love of God is just as incarnate in the life of a little baby born in Hanoi, North Vietnam, as it was two thousand years ago in the life of a little Jewish baby born in Bethlehem, Palestine.

Christmas means that at the heart of life is love and that love is the strongest thing in the world — stronger than hate, stronger than evil, stronger than death itself — and that he who loves is an angel in disguise.

Even though we may be looking at the lights on our Christmas tree through tears, we know that in spite of all our sorrows, all our fears, all our loneliness, God is good, life is good, and that the good things of life are eternal. Every great religion in the world believes this and teaches this, but Christmas is the unique Christian way of doing so. Down through the centuries Christmas has been celebrated in many ways with many strange and sometimes exotic customs, but always the meaning expressed has been the same: *life is good!*

Hanukkah

RABBI HERMAN E. SNYDER
Sinai Temple, Springfield

Hanukkah literally means *dedication*. In Judaism it is listed as a *minor holiday* but with major significance. In brief this is its background. Palestine had been conquered. Finally the Jews revolted when the foreign king desecrated the Jewish house of worship, the Temple in Jerusalem, converting it into a pagan shrine with idols and with practices in violation of the Jewish religion. The Jews battled heroically for three years until victorious. Historically, this was the first instance of any people fighting for religious liberty. The miracle was the victory of right over might, of a handful of Jews against great armies, and of the Jews without either arms or the knowledge of their use against the best equipped and skilled soldiers. But they won! Had Judaism not survived that struggle, would either Christianity or Islam have come into being?

That victory took place in 165 B.C.E. It was celebrated with an eight day dedication of the Temple which had been closed to Jewish worship. Each year this event is observed for eight days at the same season. In later years the kindling of lights was added to the observance — one light on the first night, two on the second, and finally eight on the eighth night.

This year marks the two thousand, one hundred and thirty-second anniversary of that first Hanukkah. This year it begins with the night of the twenty-sixth of December and continues for eight days. Customarily it is celebrated by relating the story (*Book of Maccabees*), festivities, the addition of appropriate prayers, the blessing and kindling of lights each night, the exchange of gifts, and particularly the remembering of those who are in need. We recall its basic significance with the daily prayer which praises God "who performed miracles for our ancestors in days of old at this season."

It calls upon us, too, to rededicate ourselves.

MEDICINE AND RELIGION

by LEROY J. KENDREW, M.D.

It has become traditional in recent years to devote the December issue of *The Hampden Hippocrat* to the activities of the Medico-Religious Committee. This has seemed appropriate in view of the religious aura surrounding this season of the year. I hope, however, that such a tradition does not have the effect of categorizing the work of the Committee into a temporal pigeon-hole, for such is not the case. The work of the Committee is continuous throughout the entire year.

Since its inception, the Medico-Religious Committee has brought together members of the medical profession — themselves of various faiths and medical interests — with clergymen representing all the major Judeo-Christian traditions. We have met regularly throughout the year to discuss the problems common to both professions which has resulted in a better understanding of our patient needs.

Over the years we have come to understand each other in a truly ecumenical atmosphere. We have respected each others' thoughts and ideas and have been able to take issue with and debate those with which we disagreed. It has indeed been a dynamic committee and one which has afforded each member a substantial personal reward. Here is an excellent example of two professions, each of which has service to the individual as its goal, working together to enhance that service.

It appears to me to be particularly relevant that members of these two professions meet on common ground. Our world is changing. In the minds of many the worship of science has gradually replaced the worship of God. Since the atom was smashed and the Sputnik launched, there has been an increasing trend to place our hope for salvation in science at the expense of our faith in God. What has been the import of this on the medical profession?

THE NEW CLERGY

In the 1967 Winchester address, given at the annual meeting of the British Medical Association, His Eminence Cardinal Heenon, Cardinal Archbishop of Westminster, referred to physicians as "the new clergy." He stated that doctors are socially more important in Britain than ever before. Since science has displaced religion in the minds of many, people now go not to the priest, minister or rabbi but to the physician "for advice of every kind." Aware of this, the Cardinal told our British colleagues: "You are the new clergy. Modern Englishmen go to the church to see their friends married and their friends and enemies buried. Apart from that they have little contact with the clergy." He went on to warn the members of the medical profession of the tremendous additional responsibility such a position entails in the counseling of their patients' moral and social life as well as in matters of health.

THE TEAM APPROACH

However, lest we take too literally the definition of M.D. ("Medical Deity"), as recently explained by the eminent psychiatrist, Lucy, to Charlie Brown in the popular Charles M. Schultz cartoon, it would be well for us to ponder the words of Dr. Melvin A. Cosberg of Long Beach, California. In a recent issue of the *J.A.M.A.* whilst discussing the patient as a "whole man," he states: "It is not the physician's place to don the cloth of the clergy and function in an area of

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theological or spiritual concern without proper qualifications; but it is his responsibility to recognize that man is a person with a spiritual birthright whose substance is far greater than the mere sum of his material components. The concept of a team approach, namely the physician and the priest, in the care of Man's illness is as ancient as the history of Man himself."

Rabbi Herschel in an address to the 113th Annual Convention of the A.M.A. in San Francisco on June 21, 1964, said it in these words. "Sickness while primarily a problem of pathology is a crisis of the total person, not only a physical disorder. The Doctor must find out the pressure of the blood and the composition of the urine, but the process of recovery also depends on the pressure of the soul and composition of the mind."

With this philosophy in mind plans are being made for the members of the Medico-Religious Committee to emerge from the committee setting and become an even more dynamic force in the healing program. We envison members of both professions observing each other in the framework of their respective workshops. Already physician members of the Committee have observed the clergy in their own individual ministries and it is hoped that the clergy may do the same in the medical field. In this manner both will have personal knowledge of the common every day problems to be faced and each will be able to contribute his training and experience. To put it succinctly, we hope to begin moving from an organizational to an operational committee.

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"M. DEITY AND B. DIVINITY"

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Senior Minister, Hope Congregational Church
Springfield, Mass., and HDMS
Medico-Religious Committee

In those welcome, but infrequent, moments when a clergyman and a member of the medical profession can sit together informally with coffee cups in hand, the conversation is usually a revelation to both of the similar role expectations under which the two professions function. It is soon clear that the self-image of doctor and cleric—that is, the way they look at and feel about themselves as individuals engaged in a special work—plays a dynamic role in the vocation of each. The self-image of men engaged in helping and healing tasks will often determine the limits of the ability of such professionals to actually provide genuine help for those who come under their care. What is terrifying to realize is that nothing quite so affects that self-image as the *tyranny of expectations.* The haunting, pursuing expectations that compel us are seldom acknowledged—except over those coffee cups. Often our expectations of ourselves, as doctors and clergy, are matters of which we are only vaguely aware. How patient or parishioner want to see us, or how they do see us, is rarely explored in terms of personal functioning. We go about our natural manner of internalizing these expectations until they become a part of the self-concept; and the one is not clearly separated from the other. Alan Gregg comments in *For Future Doctors*: "It is what our patients make of us that forges for doctors a common bond. We have all played the same role to the rest of mankind. We had to meet their expectations . . ." Any man two years beyond his ordination confesses the same to be true of his ministry. The tyranny of expectations!

In a culture where images preceed us into life experiences, both doctor and clergy find their roles somewhat cast for them by these expectations. For example, the open-heart surgeon Nicolai M. Amosoff, in his recent and dramatic book *The Open Heart*, was troubled by three roles thrust upon him. To his patients and their families, he was a demi-god; to his colleagues and students, he was a mechanical wizard always wielding the magic touch; to himself, he was a wavering uncertain doctor groping in the dark. What he felt he was never allowed to be, was the man he wanted to be. These images that surround us begin to be revealed in that coffee conversation.

EXPECTATIONS

First, there is the sense in which these expectations tend to deprive both doctor and cleric of their humanity. No one believes that underneath the bedside manner, the professional demeanor, the Latin vocabulary, the sterile diagnosis, there exists a *man*; with all the needs that being a man implies. Neither do they believe that behind the clerical collar, the everlasting compassion, the prayerful countenance, the theological verbiage, there exists a *man*; with all of the needs that

being a man conveys. Charlie Brown—or Linus—in *Peanuts* said he wanted to be a doctor, one who could do instant diagnosis and miraculous cures, to be really an *M. Deity.* In the same manner the young seminarian emerges with his B.D. degree only half-suspecting that it will be interpreted as *B. Divinity.* Therefore, it would be as shocking to a parishioner to hear a pastor say, "I have trouble believing in prayer," as it would be to the patient to have his doctor offer, "I don't know the cause of your trouble." Both the doubting parson and the baffled physician are apt to remain silent. It is small wonder that doctors and clergy hunger for human relationships in which their humanity is restored.

TYRANNY

The tragedy of this tyranny is in the subtle internalization. Several typologies seem to appear. There is the *indispensable one.* Both physician and cleric, in this case, become tireless and relentless workers, seldom taking a day off, unable to get away from office or parish. The *indispensables* are compelled and driven, keeping up the endless mythology of being infernally busy, working from dawn to dawn, without adequate rest, fatigued and weary. Doctors feed that image, as do clergymen, until laymen say to both, "I'm sorry to bother you—I know how busy you are." The tyranny manifests itself in wanting things accomplished efficiently and promptly, in an inability to live with unfinished tasks, and in a holy reluctance to assign tasks to colleagues. Very few of us are kin to good Pope John XXIII, who wrote, "The feelings of my smallness and my nothingness always kept me in good company."

There is the *omniscient one.* What has been internalized is the *authoritarian* fix, by which the professional man, in white or black gown, has all the answers to all the problems because he

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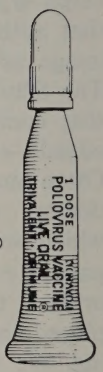

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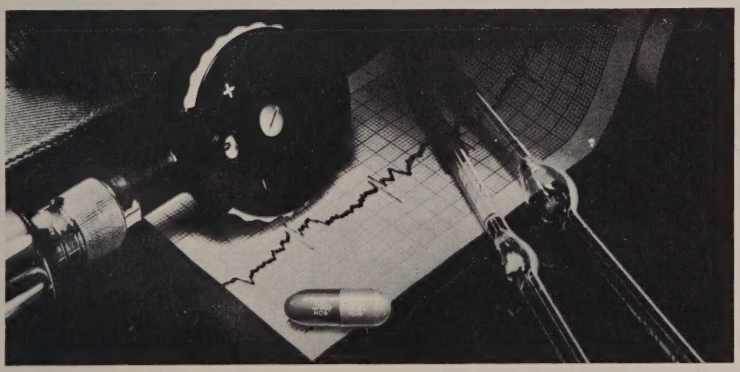
is all things to all men. It is to be seen in all of the hundreds of responses that add up to the question, "Just tell me what to do." What a temptation to be the magician, the all-knowing sage. One need not go far to find those men who lower the self-esteem of patients and parishioners by assessing them as dependent, immature persons, unable to handle the truth or to discover it for themselves. What dogmatism comes from the omniscience syndrome. No matter how much we announce and declare our specialization, all the expectations will be invested in us. Simple words, asides, and seeming inconsequentials take on an exaggeration and enhancement far beyond the commonplace meaning intended by doctor and clergyman.

A close cousin is the *perfect one*. It is easy to tell ourselves that we are pleased with nothing but the best in skill and performance, but we are doomed to failure. Neither medical man nor ecclesiastical man lives easily with failure. Patients die, surgery is not successful, marriages are not put together, anxieties are not relieved. In the professions are men who tend by the nature of their personalities to be *perfectionists*, persons who need acclaim and commendation as tokens of love and acceptance, who fear nothing quite so much as rejection at the hands of a fellow. In such need, we tend to become overly sensitive to criticism, quickly rising to the defensive. Just as the physician finds it difficult to acknowledge within himself his feeling stimulated by comments upon his skill, the clergyman finds it hard to tolerate his own feelings of resentment and anger when his own limitations are circumscribed by others. Or, consider, for example, what is described as the professional posture of *emotional neutrality* toward patient and parishioner. What is called for is perfect objectivism. What ambivalence arises when that perfection



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must be tempered with an empathetic relationship to the person involved. Moreover, how impossible to maintain objectivity when the human response is to make a judgment concerning the patient's (parishioner's) worth or acceptability as a person. It is especially acute with that large tribe of *medical shoppers* and *spiritual tramps* who look for some absolutized counsel.

OTHER KINDRED FEELINGS

There are other kindred feelings that both professions share. There is the sense of guilt in leaving cases for private pleasure and vacation periods. It is not easy to dismiss guilt when the dimension is always human need, persons in crisis, souls hovering on the brinks of disequilibrium. Guilt gets in the way of a thorough escape from the deified roles and from constant human demands.

It is refreshing to hear my medical friend confess over the coffee break how often he gets so tired that he gets to the point of having no interest in his patient's welfare. In same measure, there are more than a few days when the clergyman's source of human concern has been expended and he has no will to be with people. It is equally warming to hear the physician comment that he gets resentful of the time and energy given to medical committees, time taken from both family life and profession. Many a fine pastor chaffs under the burdens of administration and feels fulfillment only in the person-oriented moments of a ministering event. And there is so little time left for preventive medicine and education just as there is inadequate time for the clergyman's educative tasks.

In an era marked by explosions of knowledge and by scientific advancement into greater truth, there is the common problem of how to keep up-to-date. While medicine has its daily news of insights into its problems, there is an abundance of secular information shedding more light on the nature of man. No clergyman can read all of the journals, and the ones who can find ways to take sabbatical leaves for restoration and retooling are few. There is no way to solve this enigma. Each man must struggle with it as best he can, neither settling for his feelings of inadequacy nor refusing to accept such feelings. Competence is a word now marked with some disdain, a word suggesting adequacy of performance and little more. Physician and cleric will go on laboring for some disciplined way to add personal knowledge and confessing how much they need to know what they do not know.

Because of all of these expectations, men in these two professions will be *misunderstood* by some of the people some of the time, and by some of the people all of the time. Some of the criticism leveled at medicine and the ministry is deserved. Out of fatigue we tend to over-react to the charges against a cherished profession and even threaten to give it all up for the lack of appreciation for humanitarian concerns. When we are at our best, we know that we shall always be subjects of the negative feelings and projected suspicions of people.

Because of our over the coffee cup conversations, we know now that both professions have rare moments of exultation, and both experience humiliating failures when there is the sure sense that no one with such halting knowledge should be fit to practice the profession. We know that the images will persist, and that while role-breakers are not generally tolerated in either profession, there need be no tyranny of expectations if a man is emotionally mature and well-schooled in self-knowledge. Always there is the glory and the healing of those over the coffee cup moments when a physician and a clergyman can be themselves — honestly, unapologetically, and even humanly.

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A doctor must not allow himself to be influenced merely by motives of profit.

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(b) Taking part in any plan of medical care in which the doctor does not have professional independence.

(c) To receive any money in connection with services rendered to a patient other than the acceptance of a proper professional fee, or to pay any money in the same circumstances without the knowledge of the patient.

Under no circumstances is a doctor permitted to do anything that would weaken the physical or mental resistance of a human being, except from strictly therapeutic or prophylactic indications imposed in the interest of the patient.

A doctor is advised to use great caution in publishing discoveries. The same applies to methods of treatment whose value is not recognized by the profession.

When a doctor is called upon to give evidence or a certificate he should only state that which he can verify.

DUTIES OF DOCTORS TO THE SICK

A doctor must always bear in mind the importance of preserving human life from the time of conception until death.

A doctor owes to his patient complete loyalty and all the resources of his science.

Whenever an examination or a treatment is beyond his capacity, he should summon another doctor who has the necessary ability.

A doctor owes to his patient absolute secrecy on all which has been confided to him or which he knows because of the confidence entrusted to him.

A doctor must give the necessary treatment in emergency, unless he is assured that it can and will be given by others.

DUTIES OF DOCTORS TO EACH OTHER

A doctor ought to behave to his colleagues as he would have them behave to him.

A doctor must not entice patients from his colleagues.

A doctor must observe The Declaration of Geneva approved by the World Medical Association.

Our ultimate destination was Stockholm where the International Diabetes Federation (I.D.F.) was to hold its 6th trienniel Congress. With us were the Izensteins (Springfield) and a dozen or so other physicians and their wives from as near as Hartford and as far away as Indiana and Wisconsin.

TO NORWAY, THE LONG WAY

There is more than one way of reaching Bergen, a city of some 150,000 people, situated on the west coast of Norway. You can board a plane at Kennedy Airport and arrive non-stop in Bergen 6 hours later. Or you can get there the way we did — the hard way. Not that we wished it so, but our travel agency, for one reason or another, seemed to prefer it that way. Graphically plotted, our trip would strongly resemble the zigzagging ambulations of a drunk on his way home from his favorite tavern on a very dark night: Bradley to Kennedy to Amsterdam to Copenhagen to Oslo to Bergen.

A few other minor disappointments came our way, all of which were blamed on the agency. How is one to travel — solo or in groups? One advantage of the group tour is that it is easier on the pocketbook. Another, is that it promotes new friendships. This is especially true if the group is as congenial as ours proved to be. On the other hand, in group tours you don't always get the more comfortable hotel and travel accommodations.

So much for our travel travails. Once in Bergen, however, everything seemed pleasant, except for the rains. "Don't the rains ever stop here?" To this our elderly guide replied: "I really don't know. You see, I've only lived here for the past 50 years."

From Bergen we traveled most leisurely by bus and boat to Oslo. The snow capped mountains, the green shores, the blue waters of the fjords, the innumerable water falls, and the majestic forests, all combined to create a grandiose and awe inspiring panorama. By comparison Sweden and Denmark were more or less an anticlimax. However, our women found that Stockholm and Copenhagen surpassed Oslo by far when it came to shopping.

SCANDINAVIAN MEDICINE

The nature of Scandinavian medicine can be epitomized in two words—subtotal hospitalization. Hospital care is totally free to all. In the physician's office the patient pays 20-25% of the fee; the remainder is subsidized by the government. All fees are "in accordance with the prescribed tariff."

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doctors and private practitioners. Only hospital doctors are allowed to treat in-patients. This constitutes a major bone of contention on the part of the "outside" practitioner, who is forced to relinquish his patient at the hospital door. It deprives him, he argues, not only of contact with his patient but also of contact with medical progress.

Another gripe is overload and overwork. The physician shortage in the Scandinavian countries, especially in Norway, is quite acute. It's not at all unusual to see 20 or more patients crowding the average practitioner's waiting room. Add to this the mammoth amount of paper work imposed on him by governmental bureaucracy, and you have a very busy and harried physician.

The physician shortage, we learn, is caused not by a lack of graduates, but by the prevailing "brain drain." Professional opportunities, especially in the field of medical research, are apparently far greater elsewhere.

Medical economics is another reason for the professional exodus. Physicians average an annual income between 5 and 10 thousand dollars. The tax on such income is up to 70%. Norway, for instance, brags, or rather complains, of being the most heavily taxed country in the world. In addition to income tax, heavy duty is levied on imports and on luxury items. In Denmark import duty on an automobile is 100%, and all autos are imported. A package of cigarettes costs $1.20 in American money. Gasoline is 80 cents a gallon, etc., etc.

The average Scandinavian would be satisfied with the system except for the strained health services that he encounters at every turn. Waiting periods in the physician's office as well as for admission to overcrowded hospitals and nursing homes have been getting longer and longer. The total cost of health services in Sweden has increased 400% in the past 12 years. Those who can afford it prefer the benefits of private medical and hospital care. This is still readily available and is in fact steadily increasing in availability. Some do so by paying for it out of their own pocket, while others protect this privilege by carrying extra health insurance with private carriers.

THE I.D.F. CONGRESS

Attendance at the Sixth Congress of the International Diabetes Federation numbered 2,000. About 1,400 of these were physicians from 50 different coun-

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tries including, for the first time, Russia and some of its satellites. Hotel and other facilities were taxed to capacity. The scientific scene was unquestionably dominated by the 200 physicians representing the U.S.A. Although French and German were also employed, English was by far the language of choice.

Some of the 479 papers were so ultra-scientific as to make their nomenclature almost unrecognizable. This complaint was in fact voiced by one of the physicians in the audience, and he was a professor of internal medicine at one of our medical schools.

Nevertheless, even the humblest clinician had plenty to choose from. There were papers dealing with the early diagnosis and with the complications as well as with the treatment of diabetes. A 200 page volume of abstracts of the Congress is now available; a more complete report of the proceedings will be published at a later date.

A banquet was held at the Copenhagen City Hall, where the Nobel Prize banquets are usually held. An American, Dr. Rachmiel Levine, was elected President of the I.D.F. Nobel Prize winner Dr. Houssay invited everybody to come to his native Argentina in 1970 for the next congress of the I.D.F.

Most memorable was the warm hospitality accorded us by the Scandinavian people in general and the Congress personnel in particular. It was quite obvious that the Committee on Arrangements spared neither time nor effort to make all of us feel at home. Even the government extended itself beyond the call of duty. In addition to the usual words of welcome, a special cancellation stamp was established to commemorate the Sixth Congress of the I.D.F.

As we stratosphered our way home on an early August morning, we could not help reflecting that this Congress was all it was meant to be—an international meeting of medical minds. New friendships were made and old ones, renewed. Knowledge was shared and ideas, exchanged. A splendid spirit of harmony, cordiality and cooperation prevailed at all the scientific sessions and panels. "Will there come a time" one of our colleagues queried, "when a similar spirit will prevail at the meetings of our international diplomats when they gather around the conference table?"

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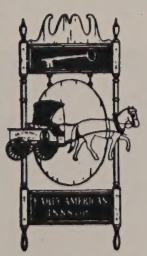

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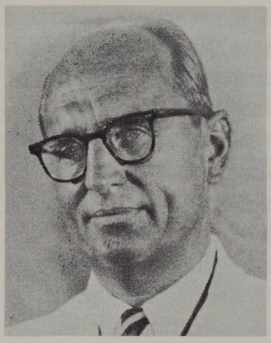

SPEAKER: ROBERT W. KISTNER, M.D.
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COMING EVENTS

HDMS MEETING, FEBRUARY 9

HDMS EXECUTIVE COMMITTEE MEETINGS, DEC. 19 and JAN. 16

MMS COUNCIL MEETING, BOSTON, MASS. FEB. 7 and MAY 20

AMA NATIONAL CONFERENCE, "THE COMMUNITY AND EMERGENCY MEDICAL SERVICES," SAN FRANCISCO, CALIF. JAN. 18 - 20

AMERICAN ACADEMY OF ORTHOPEDIC SURGEONS, CHICAGO, JAN. 20 - 25

MMS ANNUAL MEETING, BOSTON, MAY 21 - 23

AMA ANNUAL MEETING, SAN FRANCISCO, JUNE 16 - 20

Pediatric Guest Lecture

Daniel C. Shannon, M.D., Assistant in Pediatrics at the Mass. General Hospital and the Harvard Medical School, Boston, will be the pediatric guest speaker on Thursday, January 4, 1968. His topic will be "Recurrent Lower Respiratory Tract Disease and the Alteration of Host Defenses." A clinical session will be held at 5:00 P.M.; pediatric rounds at 6:00 P.M.; and the formal presentation at 8:00 P.M.

All physicians, residents, interns, nurses, and military personnel are cordially invited to attend.

Ernest A. Byron
SPRINGFIELD

CORRESPONDENCE

The Mystique of Fresh Blood

To the Editor:

The request to the blood bank for "fresh blood" is often enigmatic. All too often the request seems based on the belief that fresh blood has some mystical humoral property. All blood in the blood bank is "fresh," but sometimes the implied need for "freshly drawn" — less than six hours old — blood is justified.

The times when the use of freshly drawn blood for transfusions is justified by the patient's condition in relation to the known effects of storage on blood are surveyed by Harold A. Oberman, M.D., writing in *J.A.M.A.* (199:93, 1967). He notes that aside from good medical practice, the injudicious use of large quantities of freshly drawn blood is wasteful, for it results in excessive outdating of freshly drawn blood.

The lability of the cellular elements in whole blood is quite variable. Although there is some loss during collection, the post-transfusion viability of erythrocytes stored in ACD solution decreases by somewhat less than one percent per day. In contrast, the yield and the viability of the platelets in whole blood drawn into plastic bags is markedly reduced after 24 hours of storage in ACD at 4°C. Similarly, leukocytes have an abbreviated life-span in stored blood.

The only coagulation factors that are unstable under the usual conditions of blood bank storage are factors V and VIII. Factor IX, however, is quite stable on storage. Plasma removed from whole blood stored for 21 days in ACD at 4°C retains approximately 95 percent of its factor IX activity. "Prothrombin, factors VII, X and XI, and fibrinogen also are stable under the usual conditions of storage, so that plasma from outdated bank blood contains high levels of these factors. It should be noted that the amount of fibrinogen in a single unit of blood is insufficient to produce a significant effect in the recipient; therefore, it is best to administer this product as a concentrate," reports Dr. Oberman.

During storage, bank blood also undergoes elevations in components. There is slight elevation of plasma hemoglobin; however, transfusion of

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21-day-old blood results in only mild transient elevation of the recipient's plasma hemoglobin. Plasma potassium and ammonium concentration are also elevated. After one week of storage, both the plasma concentration and the ammonium concentration may be three or four times that in freshly drawn blood.

In patients being repeatedly transfused for chronic anemia, freshly drawn blood affords no significant advantage to the patient. Patients with thrombocytopenia will benefit most from platelets administered as concentrates or as platelet-rich plasma.

When it is necessary to prime an oxygenator, blood less than 24 hours old is desirable, although in some institutions heparinized ACD blood up to five days old is used routinely for priming, notes Dr. Oberman. Exchange transfusion for hemolytic disease of the newborn requires relatively fresh blood, but freshly drawn blood is not mandatory. "Bleeding due to deficiency of labile plasma coagulation factors is best treated with specific plasma components," says the pathologist. Blood up to seven days old meets the requirements of patients with severe acute burns who manifest hyperkalemia.

As a prime for hemodialysis, a blood less than seven days old is satisfactory. Uremic patients who manifest a bleeding tendency may be given platelet concentrates before the hemodialysis, or freshly drawn blood may be used for priming.

Thus, there are only rare indications for issuance of freshly drawn blood. In most situations an appropriate blood component, or relatively fresh blood, rather than freshly drawn blood is the treatment of choice. "Unless freshly drawn blood is used conservatively and with proper indications, such blood, or its components, will not be available for the patient who legitimately requires the product," concluded Dr. Oberman, University of Michigan, Ann Arbor.

The Committee on Blood Banks of The Hampden District Medical Society would particulary like to emphasize that "freshly drawn blood," which requires walk in donors, be used conservatively and preferably only in patients who lack a labile coagulation factor. The Committee would also like to urge all physicians to encourage their patients to replace blood when used.

John P. Sullivan, M.D.
Chairman, Advisory Board
Hampden District Medical Society
Blood Bank Committee

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SPEAKERS

Dr. John Turner spoke to Western Massachusetts Hospital nurses and the young people of the Greek Orthodox Church against smoking.

Dr. Sears spoke to the Junior Chamber of Commerce in East Longmeadow on VD and showed the movie "Quarter Million Teenagers."

Dr. Booker spoke in Wilbraham at Stony Hill School PTA on sex education and showed the movie "Human Growth."

Dr. Hill spoke at the PTA at Mapleshade School in East Longmeadow and showed both the "Innocent Party" and "Human Growth."

Dr. Joan Brady spoke at St. Cecilia's in Wilbraham on "Should We Teach Sex Education to our Youth?"

Dr. Cassella spoke on diabetes and showed the film "How Sure Are You" to the Kesser Israel Sisterhood.

Dr. Tauber and Mrs. Purdy attended the School Committee held on November 28 when the "Family Life" pilot program for the schools was approved.

PERSONALS

Dr. Donald Hayes was reelected to the Board of Governors of the American College of Surgeons.

After 32 years of practice Dr. Richard Bachmann has retired to live in St. Petersburg, Florida.

Dr. John Alifano was honored with a medal from the President of the Italian Republic for his "outstanding achievements in literary fields."

Dr. Alvin Keroack is taking a leave of absence to study radiology at Hartford Hospital. Dr. and Mrs. Keroack are parents of a new baby boy.

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NEWSPAPER SERIES

The first questions came into the office. Watch the medical page of the Springfield Daily News for the "HELP-DOC" series.

SEASON'S GREETINGS

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The Fifteenth Annual White Cap Ball

Left to right: Dr. Joseph M. Baker, President of HDMS and Mrs. Baker being greeted by Mrs. Setrag A. Zacarian, President of WAHDMS, Dr. Zacarian, Dr. Walton E. Stevens, and Mrs. Stevens, General Chairman of the "White Cap Ball."

A most delightful evening was enjoyed by some three hundred physicians and their wives who attended the fifteenth annual "White Cap Ball" on Saturday night, November 4, 1967, at the Wyckoff Park Country Club, Holyoke. Autumn flowers along with nurses' caps and lamps added to the glitter of gowns and the suave "bib and tuckers" of the festive participants who dined heartily and danced gaily.

The proceeds of this gala affair, as sponsored by the Woman's Auxiliary to the HDMS, amounted to $2,150. This sum will be used to provide scholarships during the coming year to qualified, needy students in Hampden County desirous of furthering or beginning their studies in nursing or other allied medical fields.

The committee chairmen who worked so hard to make this event such a success were: Mrs. Walton Stevens and Mrs. Bruce Stoler, general chairmen; Mrs. Setrag Zacarian, President of WAHDMS and honorary chairman; Mrs. Emmanuel Wiedman, invitations; Mrs. John Prybylo and Mrs. Richard Scott, reservations; Mrs. Bennett Burton, decorations; Mrs. Jacob Shammash, publicity; and Mrs. Walter Mozden, hostesses.

Whole hearted thanks are hereby extended to all who helped make this edition of the "White Cap Ball" a joy to be long remembered.

Louanne J. Greenspan

Publicity to the Hippocrat

AT THE

Left to right: some past presidents of the WAHDMS and their husbands — Dr. and Mrs. George L. Ross, Dr. and Mrs. Harry A. Baker and Dr. and Mrs. F. Raymond Conway.

Left to right: in attendance — Dr. and Mrs. Stephen A. Mahoney, Dr. and Mrs. Karel J. Susat, and Dr. and Mrs. Joseph R. Kelly.

BALL

Left to right: Dr. and Mrs. Bennett Barton, Dr. and Mrs. John A. Prybylo, Dr. and Mrs. Walter S. Mozden, and Dr. Mrs. Setrag A. Zacarian.

Left to right: Dr. and Mrs. Jacob B. Shammash, Dr. and Mrs. Bruce B. Stoler, Dr. and Mrs. Walton E. Stevens, and Dr. and Mrs. Emanuel Wiedman.

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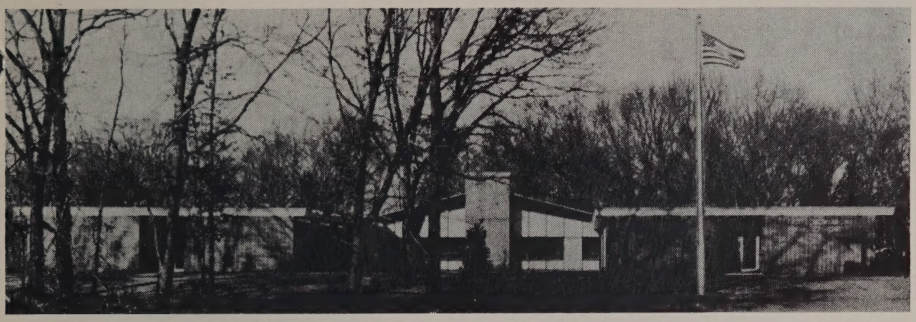

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